STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 07/14/2016

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CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

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F 000	INITIAL COMMENTS During complaint investigations of #39088, #39111, and #39182 conducted on 7/11/16 through 7/14/16 at Claiborne and Hughes Healh Center, no deficiencies were cited in relation to the complaint. Deficiencies were cited unrelated to complaint under 42CFR PART 482, Requirements for Long Term Care Facilities.	F 000		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to complete Activities of Daily Living (ADL) Flow Sheet Record forms on 5 (Resident #1, 8, 9, 10, 11) of 5 residents reviewed for pressure ulcers and on 1 (Resident #3) of 6 residents reviewed for ADLs; failed to complete the Diet Flow Sheet for 3 (Resident #2, 7, 10) of 5 residents reviewed for weight loss; and failed to document pressure ulcer care on the Treatment Administration	F 514	The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented readily accessible; and systematically organized. The clinical record will contain sufficient information to identify the resident, a record of the residents assessments; the plan of care and services provided, the results of any preadmission screening conducted by the state; and progress notes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Frances Gorge | TITLE: Administrator | (X6) DATE: 7/28/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 514	Continued From page 1 Record (TAR) for 1 (Resident #9) of 5 residents reviewed for pressure ulcers. The findings included: Review of the facility policy entitled "Turning and Positioning the Resident" revealed "...Proper positioning and regular repositioning helps to prevent pressure sores, contractures, and stagnation of respiratory secretions. Residents who are unable to reposition themselves should be turned and repositioned every 2 hours..." Medical record review revealed Resident #1 was admitted to the facility on 8/17/15 and readmitted on 6/30/16 with diagnoses including Anoxic Brain Damage due to Drug Overdose, Congestive Heart Failure, Diabetes Mellitus, Hypertension, Coronary Artery Disease, Seizures, and Right Hand Contracture. Medical record review of the Quarterly Minimum Data Set (MDS) dated 5/9/16 revealed Resident #1 was dependent on one person for dressing, bathing, grooming, and eating; had a suprapubic (directly into bladder) catheter in place; and was always incontinent of bowel. Further review revealed Resident #1 received tube feeding of Nestle Replete at 95 milliliters (ml) per hour for 22 hours and water 60 ml 6 times a day. Medical record review of the Activities of Daily Living, (ADL) Flow Sheet Record (FSR) form revealed the form was completed daily on each shift for residents to depict the resident's performance in bed mobility, transfers, toileting, dressing, fluid intake, grooming, bathing, and bowel and bladder function. Continued review of the form revealed the amount of support provided	F 514	**Corrective Action** 1. The facility reviewed Activities of Daily Living flow sheet record form and there were no negative outcomes from failure to document on resident #1,3,8,9,10, 11. The facility reviewed Diet flow sheets for resident # 2, 7,10 and there were no negative outcomes from failure to document. Pressure ulcer care on the Treatment Administration Record was reviewed for resident #9, there were no negative outcome from failure to document. The facility will ensure documentation of the Activities of Daily Living flow sheet on resident # 1,3,8,9,10,11, Diet flow sheet on resident # 2,7,10, and the Treatment Administration Record on resident # 9.	

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F 514	Continued From page 2 was also to be documented, including setup, one or two person assist, or activity did not occur the entire shift. Medical record review of the May 2016 ADL FSR form revealed 2 signatures were missing for the night shift and 2 signatures were missing for the evening shift for bed mobility which was described as "...How the resident moves to and from lying position, turns side to side, and positions body while in bed..." Review of the ADL FSR form for June 2016 for bed mobility revealed 16 signatures were missing from the day shift and 7 signatures were missing from the evening shift. Continued review of the May and June 2016 ADL FSR forms revealed there was no documentation the resident was turned and repositioned on 27 occasions due to the missing documentation. Further review of the May and June 2016 ADL FSR forms revealed many blank boxes therefore there was no documentation the facility provided basic care of toileting, dressing, grooming, and bathing. Interview with Licensed Practical Nurse (LPN) #2 on 7/12/16 at 10:15 AM on the 200 hall, and again on 7/13/16 at 12:30 PM in the anteroom confirmed, blank spaces on the ADL Flow Record meant no documentation of activity and an inability to determine if the task was completed. Medical record review revealed Resident #2 was admitted to the facility on 8/7/15 with diagnoses including Alzheimer's Dementia, Cerebrovascular Accident, Dysphagia (difficulty swallowing), and Hypertension. Medical record review of the 14 day MDS dated 7/1/16 revealed Resident #2 scored 5/15 on the	F 514	2. On 7/16/16 an audit of the Activities of Daily Living flow sheet, Diet flow sheet and the Treatment Administration Record was conducted for all residents by the unit managers all necessary corrections were made as appropriate. 3. All nursing staff were in-serviced by the Assistant Director of Nursing regarding proper completion of documentation of the Activities of Daily Living flow sheet, Diet Flow sheet and Treatment Administration Record.	

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F 514	Continued From page 3 Brief Interview for Mental Status indicating she was moderately cognitively impaired. Continued review revealed Resident #2 required limited assistance of 1 person for bed mobility, transfers, ambulation, eating, and grooming; required extensive assist of 1 person for dressing and bathing; was occasionally incontinent of bladder; and was continent of bowel. Medical record review of dietary notes dated 11/3/15 revealed Resident #2 weighed 82 pounds and was placed on a high calorie high protein diet. Continued review of a note dated 2/13/16 revealed Resident #2 weighed 76 pounds and House Supplement 240 milliliters (ml) three times daily was added to her diet. Further review of a note dated 4/15/16 revealed a Diet Flow Sheet was started with % (percentage) intake for each meal as well as fluids would be documented. Continued review of a note dated 5/16/16 revealed Resident #2 weighed 70 pounds so continued on the house supplement 3 times daily; was ordered a snack 2 times daily; and was placed on weekly weights. Further review of an Interdisciplinary Team Meeting dated 6/15/16 revealed Resident #2 was to continue on weekly weights and staff needed to encourage oral intake. Continued review of this meeting revealed the resident's family did not want Remeron or other appetite stimulants given to the resident. Further review of this meeting revealed the resident was a Do Not Resuscitate and did not want a tube inserted for artificial	F 514	4. An audit of the ADL flow sheet, Dietary flow sheet, and Treatment Administration Record will be conducted weekly x 4 by the unit Managers to ensure compliance and findings will be reported Director of Nursing and presented to the QA committee monthly.	7/27/16

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F 514	Continued From page 4 feedings. Further review of a note dated 6/15/16 revealed Resident #2 weighed 67 pounds which was a 1.4% weight loss in 7 days. Continued review of this meeting revealed the resident was still on high calorie high protein food but the family again did not want an appetite stimulant or a Speech Therapy consult. Further review of a note dated 6/21/16 revealed Resident #2 did not like Ensure so dietary would try magic cup, cottage cheese with fruit, tuna fish sandwiches, and peanut butter. Medical record review of the Dietary Flow Sheet on which all food and fluid intake of a resident is documented to serve as a reference for the dietitian to determine ways to prevent weight loss. Continued review of the sheet for April 2016 revealed amount consumed at breakfast was not documented 5 times; morning snack not documented 12 times; lunch not documented 5 times; afternoon snack not documented 11 times; supper not documented 3 times; and bedtime snack not documented 5 times. Medical record review of the Diet Flow Sheet for May 2016, revealed amount consumed at breakfast was not documented 16 times; morning snack not documented 17 times; lunch not documented 17 times; afternoon snack not documented 27 times; supper not documented 13 times; and bedtime snack not documented 31 times. Medical record review revealed Resident #3 was admitted to the facility on 4/22/16 with diagnoses	F 514		

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F 514	Continued From page 5 of Type 2 Diabetes Mellitus, Major Depressive Disorder, Peripheral Vascular Disease, Hypertension, Hallucinations, History of Falling, and Difficulty with Walking. Medical record review of the Admission MDS dated 4/29/16 revealed Resident #3 needed extensive assist with one person assist for transfer, ambulation, and toileting. Resident #3 had impairment on one side, upper and lower extremities, and always continent of bowel and bladder. Medical record review of the ADL FSR form dated April 2016 revealed there was no documentation for bowel and bladder function or the number of voids or episodes for 3 day and 3 evening shifts. Medical record review of the ADL FSR form dated May 2016 revealed there was no documentation for bowel and bladder function or the number of voids or episodes for 7 day, 16 evening, and 16 night shifts. Medical record review of the ADL FSR form dated June 2016 revealed there was no documentation for bowel and bladder function or the number of voids or episodes for 4 day, 25 evening, and 11 night shifts. Medical record review of the ADL FSR form dated July 2016 revealed there was no documentation for bowel and bladder function or the number of voids or episodes for 5 day, 6 evening and 7 night shifts. Interview with Nurse Supervisor #2 on 7/12/16 at 9:26 AM in her office confirmed, blank spaces on the ADL flow record form signified staff did not	F 514		

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F 514	Continued From page 6 document the ADL function for that day or shift. Interview with ADON (Assistant Director of Nursing) on 7/12/16 at 1:36 PM at the 2nd floor East Nurse Station confirmed, blank spaces on the ADL flow record form signified staff did not document the ADL function for that day or shift. Medical record review revealed Resident #7 was admitted to the facility on 4/8/15 with diagnoses including Dementia and Seizures. Review of the Quarterly MDS dated 7/7/16 revealed Resident #7 scored 3/15 on the BIMS indicating Resident #7 was severely impaired cognitively with disorganized thinking and wandering. Continued review revealed Resident #7 required limited assistance of 1 person with bed mobility, transfers, ambulation, dressing, grooming, and bathing; was independent with eating, and was continent of bowel and bladder. Medical record review of the Registered Dietitian's assessment dated 4/27/16 revealed the resident's weight has been stable the last few weeks. Continued review revealed "...current weight 96 pounds is within ideal body weight for resident's height. PO (oral) intake of diet alone does not meet estimated nutritional needs but the additional calories and protein from supplements and snacks meets resident's needs..." Medical record review of the Diet Flow Sheet for April 2016 revealed no signature 6 times at breakfast, 12 times for morning snack, 6 times for lunch, 13 times for afternoon snack, and 4 for supper. Medical record review of the Diet Flow Sheet for	F 514		

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F 514	Continued From page 7 May 2016 revealed missing signatures 15 times for breakfast, 31 times for morning snack, 16 times for lunch, 31 times for afternoon snack, 21 times for supper, and 31 times for bedtime snack. Medical record review revealed Resident #8 was admitted to the facility on 6/2/16 and readmitted on 6/17/16 with diagnoses including Cerebrovascular Accident/Subarachnoid Hemorrhage, Tracheostomy, Stage IV Sacral Decubitus with Osteomyelitis, Above Knee Amputation, Hypertension, Gastroesophageal Reflux Disease, and Peripheral Vascular Disease. Medical record review of the Admission MDS dated 6/24/16 revealed Resident #8 was dependent on 2 people for dressing and bathing; dependent on one person for eating (tube feeding) and grooming; had a Foley catheter in place, and was always incontinent of bowel. . Review of the ADL FSR form for June 2016 revealed no documentation as follows: 1. Bed mobility - 3 times on day and 4 times on evening shifts 2. Dressing - 1 time on night, 3 times on day, and 4 times on evening shifts 3. Grooming - 1 time on night, 4 times on day, and 3 times on evening shifts 4. Bathing - 1 time on night, 5 times on day, and 4 times on evening shifts 5. Of the Foley catheter output - 1 time on night, 6 times on day, and 5 times on evening shifts. Interview with LPN #2 on 7/12/16 at 10:15 AM on the 200 hall, and again on 7/13/16 at 12:30 PM in the anteroom, after reviewing the ADL FSR form for Resident #8 confirmed, blank spaces on the ADL FSR form meant no documentation of	F 514		

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F 514	Continued From page 8	F 514		

activity and an inability to determine if the task was completed.

Medical record review revealed Resident #9 was admitted to the facility on 3/4/16 with diagnoses of Chronic Sacral Decubitus, Chronic Deep Vein Thrombosis, Recurrent Aspiration and Dysphagia, Quadriplegia, Chronic Foley Catheter, Seizure Disorder, Insomnia, Ileostomy, Gastrostomy, Chronic Pain with Baclofen Pump, and Gastroesophageal Reflux Disease.

Medical record review of the Quarterly MDS dated 6/10/16 revealed Resident #9 needed total assist with two person assist for bed mobility and toileting. Resident #9 had impairment on both sides, upper and lower extremities (quadriplegic). The resident had a Foley catheter and ileostomy.

Medical record review of the ADL FSR form dated April 2016 revealed no documentation for bed mobility for 1 day and 10 evening shifts.

Medical record review of the ADL FSR form dated May 2016 revealed no documentation for bed mobility and bowel and bladder function or the number of voids or episodes for 18 day and 23 evening shifts.

Medical record review of the ADL FSR form dated June 2016 revealed no documentation for bed mobility and bowel and bladder function or the number of voids or episodes for 18 day, 15 night, and 7 evening shifts.

Medical record review of the ADL FSR form dated July 2016 revealed no documentation for bed mobility and bowel and bladder function or the number of voids or episodes for 4 day, 3 night,

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F 514	Continued From page 9 and 3 evening shifts. Medical record review of the Treatment Administration Record (TAR) dated April 2016 revealed the wound treatment of "...Clean upper right ischium with chlorhexadine, pack with dakin soaked gauze and cover with dry dressing daily at 4 PM..." Further review revealed no documentation for wound treatment for right upper ischium for 10 of 26 opportunities . Medical record review of the TAR dated June 2016 revealed the wound treatment of "...Clean left and right heel with Chlorhexidine, pack with dakin soaked sterile packing gauze, wrap with dry dressing daily at 4 PM...and Clean upper left buttocks with Chlorhexidine, apply santyl, pack with sterile packing gauze and apply dry dressing daily at 4 PM..." Further review revealed no documentation for wound treatment for the right and left heels and the upper left buttocks for 3 of 21 opportunities. Medical record review of the TAR dated July 2016 revealed the wound treatment of "...Clean left and right heel with Chlorhexidine, pack with dakin soaked sterile packing gauze, wrap with dry dressing daily at 4 PM...Clean upper left buttocks with Chlorhexidine, apply santyl, pack with sterile packing gauze and apply dry dressing daily at 4 PM..." Further review revealed no documentation for wound treatment for the right and left heels and the upper left buttocks for 1 of 6 opportunities. Interview with Nurse Supervisor #2 on 7/12/16 at 9:26 AM in her office confirmed, blank spaces on the TAR signified staff did not document the treatment as ordered.	F 514		

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F 514	Continued From page 10 Interview with ADON on 7/12/16 at 1:36 AM at the 2nd floor East Nurse Station confirmed blank spaces on the TAR signified staff did not document the treatment for that day or shift. Medical record review revealed Resident #10 was admitted to the facility on 4/16/16 with diagnoses including Dementia and Macular Degeneration. Medical record review of the 60 day MDS dated 6/17/16 revealed Resident #10 scored 1/15 on the BIMS indicating he was severely impaired cognitively; was dependent on 2 staff for transfer and bed mobility; was dependent on 1 person for dressing, eating, and bathing; and was always incontinent of bowel and bladder. Medical record review of the wound care notes dated 7/8/16 revealed Resident #10 had a Stage III pressure ulcer to the sacrum measuring 1.6 cm x 1.3 cm x 0.3 cm with 65% granulation. Continued review revealed a wound of the left medial thigh measuring 2.1 cm x 2.3 cm x 0.6 cm with 60% granulation. Medical record review of the ADL FSR form revealed no documentation of bed mobility on 13 day and 15 evening shifts; no documentation of transfers, dressing, eating, grooming, bowel, and bladder on 13 day shifts for each and 15 on evening shifts for each. Medical record review of dietary notes dated 5/26/15 revealed Resident #10 had an 11 pound weight loss in 7 days while consuming 50 - 100% of meals. Continued review revealed the resident was on a puree diet with high calorie high protein added to current diet order, and he was also	F 514		

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F 514	Continued From page 11 placed on the Red Napkin program. Medical record review of dietary notes dated 6/1/16 revealed Resident #10 had lost 5 pounds in 7 days. Continued review revealed Speech Therapy (ST) felt the wound pain was a contributing factor to the patient's inability to eat meals. Further interview revealed ST suggested 6 small meals daily, add Arginaid (protein powder) daily, sandwiches between meals, and house supplement between meals. Medical record review of dietary notes dated 6/8/16 revealed Resident #10 had lost 3 pounds in 7 days while eating 25 - 50% of puree diet. Continued interview revealed the house supplement was increased to 3 times daily as well as a snack three times daily. Medical record review of dietary notes dated 6/29/16 revealed Resident #10 had a 6 pound weight loss in 7 days while consuming 25 - 75% of puree high calorie high protein diet. Continued review revealed Resident #10 received snacks 3 times daily, house supplement of 240 ml 3 times daily, and food preferences were updated. Medical record review of the Diet Flow Sheet for April 2016 revealed 3 signatures missing for breakfast; 11 signatures missing for morning snack, 4 for lunch, 11 for afternoon snack, 7 for supper, and 11 for bedtime snack. Medical record review of the Diet Flow Sheet for May 2016 revealed 12 signatures missing for breakfast, 31 for morning snack, 16 for lunch, 31 for afternoon snack, 22 for supper, and 31 for bedtime snack.	F 514		

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F 514	Continued From page 12 Interview with LPN #2 on 7/12/16 at 10:15 AM on the 200 hall, and again on 7/13/16 at 12:30 PM in the anteroom, after reviewing the ADL FSR form for Resident #10 confirmed, blank spaces on the ADL FSR form meant no documentation of activity and an inability to determine if the task was completed. Medical record review revealed Resident #11 was admitted to the facility on 4/12/16 with diagnoses including Cerebrovascular Accident, Acute Kidney Failure, Restless Leg Syndrome, Dysphagia (difficulty swallowing), Transient Ischemic Attack; Dementia, Hypertension, and Atrial Fibrillation. Medical record review of the 14 day MDS dated 6/29/16 revealed Resident #11 was dependent on one person for transfers and grooming; required extensive assistance of one person with bed mobility, dressing, eating, bathing, and was always incontinent of bowel and bladder. Medical record review of the wound care notes dated 7/8/16 revealed Resident #11 had a Stage III pressure ulcer to the right heel, measuring 0.8 cm x 2.0 cm x 0.4 cm, with 100% granulation. Continued review revealed Resident #11 also had a wound to the left upper chin measuring 2.5 cm x 2.5 cm x 0.3 cm with 50% granulation. Medical record review of the ADL FSR form DATED???? revealed no documentation of bed mobility, transfers, dressing, grooming, bathing, and bowel and bladder on 10 day and 15 evening shifts for each of the areas. Interview with LPN #2 on 7/12/16 at 10:15 AM on the 200 hall, and again on 7/13/16 at 12:30 PM in the anteroom, after reviewing the ADL FSR form	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 13 for Resident #11 confirmed, blank spaces on the ADL FSR form meant no documentation of activity and an inability to determine if the task was completed.	F 514		